ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION TO STUDENT

Name of Student	Birth Date	ID Number
Address	Telephone Number	Zip Code

The above named student has _____
Name of Disease or Syndrome

I am requesting that the above named student be administered the following medication during school hours:

Name of Medication	Type of Medication, i.e. Tablet, Liquid, Inhaler
Dosage	Route	Time to be given

_____
Possible Side Effects

The phone number where I may be reached in the event of a reaction to the medication or an emergency is:

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____**Fax #**_____

Physician's Signature _____**Date** _____

***This request is valid for 1 year from date of signature. Any change in medication or dose requires a new request form.**